

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05795

43

Reg. Dist. No. 51

1. PLACE OF DEATH:

County CatonsvilleCity or town Port Republic
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ohio County FranklinCity or town Columbus
(If outside city or town limits, write RURAL and give nearest town)Street No. 1867 Summit St
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Lucia S. Addison

3. (b) Social Security Number

4. Sex F5. Color or race W6. (a) Single, married, widowed, or divorced W

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 18, 18768. AGE: Years 69 Months 11 Days 21 It less than one day
hrs. min.9. Birthplace Ohio
(Town, county, and state)10. Usual occupation Domestic

11. Industry or business

12. Name Deborah F. Sherbondy13. Birthplace Pa.14. Maiden name Charlotte L. Defters15. Birthplace Mass.16. Informant C. F. ChadwickAddress 6301, 16th St NW, Wash DC17. Burial Date thereof (month) (day) (year)Cemetery or crematory Lorraine ParkLocation Baltimore, Md.18. Funeral director NinesAddress Washington, D.C.19. 6-9 19 46 N.W. Ward

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/19 19 46 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 46 to 19 46and that I last saw him alive on 19 46Immediate cause of death Cowdria pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.W. Ward

M. D. or other

Address Wash DC Date signed

RECEIVED

JUN 12 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

05796

Reg. Dist. No. 5/

1. PLACE OF DEATH

County Calvert
 City or town Calverton
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (d) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age 50 years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CalvertCity or town Calverton
(If outside city or town limits, write RURAL and give nearest town)Street No. 1st Republic
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/30 46 at 7:17 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 46 to 19 46and that I last saw him alive on 6/30 19 46

Immediate cause of death

DURATION

Cerebral hemorrhage 2 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings and operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

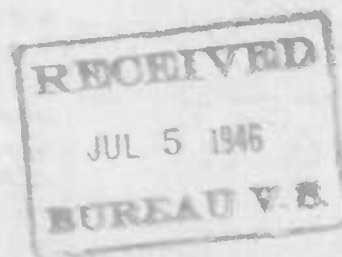
Injured at work?

23. SIGNATURE

M. D. 6/30/46

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7451

1. PLACE OF DEATH:

County... CalvertCity or town... Prince Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Calvert Co., 7 Hospital

How long in hospital or institution?

3. (a) FULL NAME

John A. Culp Sr.

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ruth C. Culp

7. Birth date of

deceased (mo., day, yr.)

June 1, 1898

6. (c) If alive, give age... years

8. AGE:

Years

48

Months

0

Days

29

If less than one day

hrs. min.

9. Birthplace

South Carolina

(Town, county, and state)

10. Usual occupation

Cal. Driver

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date read by Registrar)

19. 46

Registrar

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h... alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED
JUL 10 1946
BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

05798

42

Reg. Dist. No. 51

1. PLACE OF DEATH:

County..... Calvert
 City or town..... Bowens
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Jiporah Dale

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

X

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March, 13, 1855

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

91

..... hrs. min.

9. Birthplace

md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 46

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

6-8-46

19. 46 at

7:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15

19. 46 to

June 8

19. 46

and that I last saw him alive on

19.

Immediate cause of death

Heart failure

Due to

Due to

Arterio-sclerotic c.v. d.

Other conditions

Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

Dr. J. L. Williams M.D.
Prince Frederick
6/11/46

RECEIVED
JUN 12 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05799

Reg. Dist. No. 5-2

1. PLACE OF DEATH:

County CalvertCity or town Sunderland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CalvertCity or town Sunderland
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Louis C. Jones

3. (b) Social Security Number

4. Sex

M.

5. Color or race

C

6.(a) Single, married, widowed, or divorced

X

6.(b) Name of husband or wife

Ivory Jones

7. Birth date of

deceased (mo., day, yr.)

May 30, 18946.(c) If alive, give age 44 years

8. AGE:

Years

Months

Days

If less than one day

52

hrs.

min.

9. Birthplace

md

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER
MOTHER

12. Name

Louis H. Jones

13. Birthplace

Pum Point, Calvert Co. Md.

14. Maiden name

Madona Gross

15. Birthplace

md

16. Informant

Ivory Jones

Address

etc Paris, md

17.

(Burial, cremation, or removal. Which?)

Date thereof

6-16-46
(month) (day) (year)

Cemetery or crematory

St. Edmonds

Location

Calvert

18. Funeral director

P. E. Seewell

Address

Prince Frederick, md

19.

(Date rec'd by registrar)

6-15-46Virgie P. Carpenter
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

6-13-46 at 4:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/9/46 1946, to 6/13 1946
and that I last saw him alive on 6/13 1946

Immediate cause of death

Subd. Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Prince Frederick, md Date signed 6/14/46

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JUN 21 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

05800

Reg. Dist. No. 52

1. PLACE OF DEATH:

County CalvertCity or town Sunderland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CalvertCity or town Sunderland, Huntingtown
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

John E. Mackall

3. (b) Social Security Number

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

X

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 1-2-5-1869

8. AGE:

Years

Months

Days

If less than one day

77

_____ hrs. _____ min.

9. Birthplace md
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name James Mackall13. Birthplace md14. Maiden name F

15. Birthplace

16. Informant Alonzo MackallAddress Huntingtown, md.17. Burial Date thereof 6-6-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory PatuxentLocation Calvert18. Funeral director P. E. SuwellAddress Prince Frederick19. June 5 1946 N. W. Ward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3rd 1946 at 6 P.M. 40

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

HemoptysisDue to Pulmonary Tuberculosis

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE R. E. Tillman M. D. or otherAddress Prince Frederick Date signed June 5

RECEIVED
JUN 7 1946
BUREAU V R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

05801

20

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:

County CalvertCity or town N. Beach
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? until

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. CountyCity or town Wash. DC
(If outside city or town limits, write RURAL and give nearest town)Street No. 2428 14th St. N.W.
(If rural, give LOCATION) ✓

2.(a) If veteran, name war

3. (a) FULL NAME

Sarah K. Mendelson

3. (b) Social Security Number

4. Sex F5. Color or race W6.(a) Single, married, widowed, or divorced widowed6.(b) Name of husband or wife Hyman7. Birth date of deceased (mo., day, yr.) Dec. 1884
B.(c) If alive, give age..... years8. AGE: Years 61 Months _____ Days _____
If less than one day _____ hrs. _____ min.9. Birthplace Russia
(Town, county, and state)10. Usual occupation H.W.11. Industry or business Home12. Name Jacob Keres13. Birthplace Russia14. Maiden name Rose (unknown)15. Birthplace Russia16. Informant Alfred MendelsonAddress 4401 Sheriff Rd. Wash. DC17. (Burial, cremation or removal, which?) IntermentDate thereof (month) (day) (year) June 28 1946Cemetery or crematorium Evereth Darrel CemeteryLocation Washington DC18. Funeral director Greens Funeral HomeAddress 4217-9th St Wash. D.C. N.W.19. June 28 1946 Grace R. Hutchins
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 June 1946 at 2:15 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 June 1946 to 27 June 1946
and that I last saw him alive on 26 June 1946Immediate cause of death chronic myocarditis

DURATION

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alfred Mendelson M. D. or otherAddress Hutchins Washington DC Date signed 27 June 46

RECEIVED

JUL 5 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH
County Calvert
City or town Crofton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Calvert
City or town Crofton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Alma Meyers

3. (b) Social Security Number

4. Sex F 5. Color or race C 6.(a) Single, married, widowed, or divorced S
6.(b) Name of husband or wife
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) 3/3/41
8. AGE: Years 5 Months 3 Days 15 If less than one day
..... hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Alma Meyers

13. Birthplace Md

14. Maiden name Elaine White

15. Birthplace Md

16. Informant Elaine White

Address Crofton

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 6-18-46
(month) (day) (year)

Cemetery or crematory St. Johns

Location Appel, Md

18. Funeral director James White

Address Crofton, Md

19. 6-18-46 N W Ward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18-46 at 7:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to 19.....

and that I last saw him..... alive on 19.....

Immediate cause of death Buried to death

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 6/18/46

Where did injury occur? Crofton Calvert Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fire Injured at work? in bed

23. SIGNATURE W W Ward M. D. or other

Address Crofton, Md Date signed

RECEIVED
JUN 19 1946
BUREAU OF S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 05803
 Reg. Dist. No. 51

1. PLACE OF DEATH:

County CecilCity or town Cato
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CecilCity or town Cato
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

4. Sex M5. Color or race C6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife _____

7. Birth date of

deceased (mo., day, yr.)

4/17/41 (T)

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

521

_____ hrs.

_____ min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Elvin Mayers13. Birthplace MD

MOTHER

14. Maiden name Elvin White15. Birthplace MD16. Informant Elvin WhiteAddress Cato

17.

(Burial, cremation, or removal. Which?)

Date thereof

6-18-46
(month) (day) (year)Cemetery or crematory St. JohnsLocation Appeal, MD18. Funeral director James WhiteAddress Cato, MD

19.

(Date rec'd by registrar)

19 46Newland

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18 19 46 at 7:24 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 _____, to

19 _____

and that I last saw _____

alive on

19 _____

Immediate cause of death

Burned to death

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6/18/46Where did injury occur? Cato Cecil MD
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Fire Injured at work? in bed23. SIGNATURE Dr. [Signature]

M. D. or other

Address Cato, MD

Date signed _____

10000

RECEIVED
JUN 19 1946
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

05804

Reg. Dist. No. 52

1. PLACE OF DEATH:

County CalvertCity or town Dunkirk
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CalvertCity or town Dunkirk
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

Charles Parker

3. (b) Social Security Number

none4. Sex m 5. Color or race C 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Matilda Parker7. Birth date of deceased (mo., day, yr.) June 1 1885 6. (c) If alive, give age 61 years8. AGE: Years 61 Months 0 Days 0 It less than one day _____ hrs. _____ min.9. Birthplace Lothian Md.
(Town, county, and state)10. Usual occupation Farm hand11. Industry or business Farming12. Name I. S. DC PARKER13. Birthplace Lothian Md.14. Maiden name Unknown

15. Birthplace _____

16. Informant Bernard HardistyAddress Galesville Md.17. Burial Date thereof 6/5/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory AdamsLocation Lothian Md.18. Funeral director T. A. Hardisty & SonAddress Galesville Md.19. June 4 19 46 Wm. J. French
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 19 46 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 7 19 46 to June 1 19 46and that I last saw him alive on May 20 19 46Immediate cause of death myocarditis (chronic)Due to arteriosclerosis,coronary disease

Due to _____

Other conditions _____

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Emily H. WilsonAddress Lothian M. D. or other _____Date signed 5/3/46

RETURN TO POSTAL AND TELEGRAPH

RETURN TO POSTAL AND TELEGRAPH

RECEIVED

JUN 5 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MEDICAL CERTIFICATION

20. DATE OF DEATH

6/29

1946

at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19

to

19

and that I last saw it

alive on

19

Immediate cause of death

Drown

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

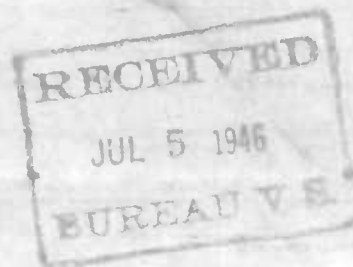
18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Md

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:

County CalvertCity or town Sunderland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CalvertCity or town Sunderland
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Baley girl Smith

3. (b) Social Security Number

4. Sex F 5. Color or race C 6.(a) Single, married, widowed, or divorced single

8.(b) Name of husband or wife _____

5.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 5 June 468. AGE: Years _____ Months _____ Days 3 If less than one day _____ hrs. _____ min.9. Birthplace Sunderland Md
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER 12. Name Albert Smith13. Birthplace MdMOTHER 14. Maiden name Van Hilsen15. Birthplace Md

16. Informant _____

Address _____

17. Burial Date thereof _____
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt Hope Cem.Location Sunderland18. Funeral director Grace Smith (sister)Address Sunderland19. June 9 19 46 Grace P. Hutchins
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 June 1946, at 7:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 46 to 8 June 1946
and that I last saw him alive on 6 June 1946

Immediate cause of death _____

Human lungs given born.

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Alfred Red

M. D. or other

Address Hawthorne Date signed 8 June 46

RECEIVED

JUL 5 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
of deceased is shown on 2411 N. Charles St., Baltimore (80)

CERTIFICATE OF DEATH

Reg. Dist. No. 51

FILM No. 106 AUG 16 1946

1. PLACE OF DEATH:

County Calvert

City or town Crofton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Calvert

City or town Crofton
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Russell J. White

3. (b) Social Security Number

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

single

8. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Oct 17, 1942

8. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

2

3

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Albert Bougle

13. Birthplace

Md

14. Maiden name

Elsie White

15. Birthplace

Md

16. Informant

Elsie White

Address

Crofton

17.

(Burial, cremation, or removal. Which?)

Date thereof

6-18-46

(month) (day) (year)

Cemetery or crematory

St. Johns

Location

Appelton

18. Funeral director

James White

Address

Crofton, Md

19.

(Date rec'd by registrar)

6-18-46

N W Ward

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18/46 19 _____ at 7:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 _____

to

19 _____

and that I last saw him

alive on

19 _____

Immediate cause of death

Burned to death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

accident

Date of

6/18/46

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Home

Means of injury

Fire

Injured at work?

in bed

23. SIGNATURE

H W Ward

M. D. or other

Address

Crofton, Md

Date signed

RECEIVED

JUN 19 1946

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH
County Prince Georges
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County Washington
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1243-5th St NW
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
William W. Young

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Mar
6.(b) Name of husband or wife Frederick W. Young
7. Birth date of deceased (mo., day, yr.) April 29/1922
8. AGE: Years 24 Months 0 Days 0 If less than one day
.....hrs.min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business at home
12. Name William W. Young
13. Birthplace Washington, D.C.
14. Maiden name Young
15. Birthplace Washington, D.C.

16. Informant Frederick W. Young
Address 1243-5th St NW, Wash. D.C.
17. (Burial, cremation, or removal) Which Burial Date thereof 7 3 46
(month) (day) (year)
Cemetery or crematory Halls Creek
Location Springfield
18. Funeral director P. Sewell
Address Frederick W. Young
19. (Date rec'd by registrar) 7/3/46 Registrar Frederick W. Young

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 30 46 at 9 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
..... 19..... to 19.....
and that I last saw him 19.....
alive on 19.....

Immediate cause of death
Dead at open
wound

DURATION

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Homicide Date of 6/30/46
Where did injury occur Living Room (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Struck with ax Injured at work?

23. SIGNATURE Frederick W. Young M. D. other
Address Frederick W. Young Date signed 7/3/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 5 1946

BUREAU V.A.